DOCUMENT RESUME

ED 243 860 SP 024 281

AUTHOR Morrow, Marilyn J.; Doyle, Kathleen
TITLE Elder Abuse Awareness Project.
PUB DATE Mar 84
NOTE 25p.; Paper presented at the Annual Convention of the American Alliance for Health, Physical Education, Recreation and Dance (Anaheim, CA, March 29-April 2, 1984).
AVAILABLE FROM Copies of materials developed by this project available upon request: C.A.D.V., P. O. Box 732, Charleston, IL 61920 Attention: Elder Abuse Awareness Project.
PUB TYPE Speeches/Conference Papers (150) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Community Services; *Crisis Intervention; *Elder Abuse; *Family Problems; *Human Services; Interpersonal Relationship; Negative Attitudes; *Older Adults; *Problem Solving; Social Support Groups; Stress Variables

ABSTRACT

The Elder Abuse Awareness Project was developed to determine the incidence of abuse and neglect of elderly people in several rural counties in central Illinois. A primary purpose of the study was to survey service providers as to their actual encounters with elder abuse and neglect. Each provider was asked about warning signs or cues that were indications that something was fundamentally wrong or that a senior could be a possible victim of abuse. Two standard responses were suspicious injuries and inconsistency of behavior. However, seven other general categories emerged: (1) medical manifestations; (2) interpersonal relationships; (3) neglect; (4) home and living environment; (5) finances; (6) depression; and (7) physical disintegration. Three problems were identified: (1) the need to address legal issues; (2) the lack of protective service by providers; and (3) an undeveloped set of services to address the issue. Recommendations are given for solving various problems in the elder abuse area. Products developed from the findings of the study and intended as aides to providers of services to the elderly include a set of transparencies and slides coordinated with an audio tape as a "Packaged Program" for seniors; a general brochure describing elder abuse and its symptoms, and giving information and referral numbers; a general informational booklet based on the audio visual materials; an intake card; and a final report. (JD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED243860

ELDER ABUSE AWARENESS PROJECT

Marilyn J. Morrow, M.A.
Instructor
Kathleen Doyle, Ph.D.
Assistant Professor
Health Education Department
Eastern Illinois University
Charleston, Illinois 61920

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Kathleen Doyle
Marilyn Morrow

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Paper presented at American Alliance for Health, Physical Education, Recreation and Dance, National Convention, Anaheim, California, March 1984.

SP 024 281

ELDER ABUSE AWARENESS PROJECT

Introduction

Until 1978, little or no information was published concerning domestic abuse or neglect of older people in their homes by relatives or other caregivers. During 1978 and 1980, six separate studies were conducted to begin this investigation (Douglass, 1983). All of these investigations agree that a substantial but undocumented problem of elder abuse and neglect exists. The degree of abuse ranged from moderate to severe life-threatening situations. Possible causes are now being examined by professionals but obviously the need for more research continues.

The population of the United States is rapidly aging, and by the year 2,000 about 20 percent of the population will be over age 60 (U. S. Bureau of the Census, 1980). The number of persons, age 75 or older, is the fastest growing segment of the population (U. S. Bureau of the Census, 1980). A larger population of the elderly with longer life expectancy will also require higher levels of personl care and for longer periods of time. The medical care system, nursing homes, and other

long term care facilities will need to gear-up to meet some of the responsibility. However, the population trends suggest that a growing number of dependent elderly will be in the care of their adult children and relatives.

Although studies vary, it is estimated that there are between 500,000 and 2.5 million cases of elder abuse or neglect each year (Coyle, 1983). While exact data is still not available, the House Select Committee on Aging in 1981 reached several conclusions as a result of a full-scale, national study on the extent of abuse and neglect. Their published study revealed that elder abuse is as prevalent as child abuse, but is less likely to be reported. Physical violence is the most common type, followed by material abuse, the denial of constitutional rights, and psychological abuse. The victims are most likely to be female, 75 or older, and dependent on others for care and support. Typically, the abuser will be under a great deal of stress and often is the son, daughter, or spouse of the victim. Twenty-six states have adult protective laws, but most acknowledge that these laws are basically ineffective in dealing with the problem.

In 1981, a major study was completed which attempted to determine the extent of elder abuse and neglect in Illinois. The state was divided into five regions, and samples were drawn from each. Researchers gathered information from individuals in the community who were

involved with older people. A questionnaire was sent to other service providers. This study found that abuse and neglect of older persons in Illinois nearly equals the number of cases of child abuse and neglect (Crouse et al., 1981).

Statistically it is very difficult to document elder abuse. As a recent Illinois study on Abuse and Neglect of the Elderly in Illinois noted, "Abuse of the elderly is an example of behavior whose prevalence, like that of rape or spouse abuse, is difficult to determine" (Crouse et al., 1981). In evaluating methods to combat elder abuse, the study concluded, "The domestic violence model is quite good for protecting many victims of family violence and would be a valuable assistance for abused elderly" (Crouse et al., 1981).

Background and Purpose

The Coalition Against Domestic Violence in Charleston, Illinois serves families in violent crisis situations in Coles, Clark, Cumberland, Douglas, Edgar, Shelby, and Moultrie counties. Services include a twenty-four hour hotline, temporary shelter, crisis intervention, advocacy, and emergency transportation. No fees are charged and these services are available to anyone regardless of sex, age, economic or social status.

However, the Illinois Domestic Violence Act as amended in the spring of 1982 included a broader definition of domestic violence to include "seniors" and also extends orders of protection to them. Since the C.A.D.V. derives legal parameters for cases of domestic violence through this legislation, "elder abuse" has become a more defined element of our program.

Consequently, the Coalition AGainst Domestic Violence submitted a proposal to the East Central Illinois Area Agency on Aging to develop, produce, and distribute educational materials for the professional service provider and for seniors per se on elder abuse as a component of domestic violence and on the services available through the C.A.D.V. The grant was funded through Title III of the Older Americans Act.

Methods and Procedures

The Elder Abuse Awareness Project was developed to determine the incidence of abuse and neglect in seven counties in central Illinois. These counties included Clark, Coles, Cumberland, Douglas, Edgar, Moultrie, and Shelby.

As stated in the grant proposal the goals of the project for service providers were:

1. to provide greater awareness of elder abuse
2. to provide specific information about the C.A.D.V. as one model of dealing with elder abuse
3. to provide information about the advocacy model

To accomplish these goals:

1. an extensive review and research of the literature on elder abuse was undertaken
2. service providers in Coles, Cumberland, Clark, Douglas, Shelby, Moultrie, and Edgar counties were interviewed as to their perceptions of elder abuse in their county. The service providers were asked to respond to four questions: (1) have you seen elder abuse and neglect in your work? If so, what was the nature of the abuse? (2) what are possible warning signs of stress that might cause a service provider to suspect abuse or neglect? (3) are there some trust-building techniques that could be used in bridging communication problems between service providers and older clients? (4) what are "red flags" or obstacles to building trust and communication with older clients and their families?

3. based on the literature review and interviews, the audio/visual materials were developed specifically for service providers and field tested.
4. after the materials were field tested and refined, the materials were produced and distributed to service providers through direct mail, personal contact, and in-service programs.

As stated in the grant proposal the goals of the project for seniors per se were:

1. to provide general information about elder abuse
2. to provide specific information about elder abuse as a component of domestic violence
3. to provide information about specific services offered by the Coalition Against Domestic Violence

To accomplish these goals:

1. an extensive review and research of the literature on elder abuse was undertaken
2. an advisory council of R.S.V.P. volunteers reviewed the audio/visual material. (Seniors were willing to review the project's materials and discuss elder abuse in that context, but were unwilling to have a general discussion prior to the development of the

materials.)

3. after the materials were field tested and refined, the materials were produced and distributed to seniors through direct mail, programs at nutrition sites, and presentations at clubs and organizations

Results

Incidence and Prevalence

It was a primary purpose of this study to survey service providers as to their actual encounters with elder abuse or neglect. This was somewhat problematic because clear lines between the different types have not been drawn in research. It was decided that the providers should attempt to relate their experiences and not attempt to classify the examples under any particular type.

Some providers admitted that they had not encountered any cases. It is their concern that older people in their areas may be victims, but do not or will not use services. In smaller communities, there is a general feeling of no telling problems to strangers which may include service providers. In smaller communities, many of the older residents have grown up together, watch out for each other, and resolve or live with family conflicts without seeking outside aid. These providers felt there were probably cases in their areas but for these reasons, it had not been brought to the attention of their agencies.

A second classification was providers that believed their clients were neglected by family members. These providers felt that much of the neglect was due to ignorance of the family caregiver who may not be knowledgeable of the needs of the older person. Neglect may be a part of apathy; simply not caring about the older person.

The most common type of neglect cited was refusal to change bedding or clothing or refusal to provide proper meals. A common problem among service providers who enter the home is that they train and instruct the caregiver, but often return to the home to find that nothing was done.

The more serious forms of abuse were seen by some providers although the majority of cases seemed to be problems of neglect. Many providers reported seeing psychological abuse especially yelling, using profanity, and threatening the older person with institutionalization. Mismanagement of the older person's finances was seen by several providers. One provider felt that an older client was being overmedicated to keep the person quiet. There were two cases of physical abuse suspected but in both cases, the person would not substantiate how the injuries occurred.

The abuser was usually the spouse, the son, or daughter of the victim. In several cases, it was the paid caregiver. Service providers indicated some possible causes. In the case of neglect, it seems to be a

matter of apathy or ignorance.. But in cases of a more serious nature, the providers felt that it is a generational conflict since the middle generation may be meeting the demands of both their children and older family members.

Providers often expressed the concern that alcohol may be the precipitating factor in many cases. A person under great stress would be capable of neglecting or abusing the older person if alcohol abuse was present also.

A third reason may be the refusal of many older people to accept help from outside sources. The older person may not seek agency help because he or she sees that as a reduction in their independence. However, needed services may be one method of maintaining that person in his/her home and reducing the caregiving responsibilities of families. It is the challenge to service providers to outreach and present services in such a way so that the client views it as a means to maintain independence, not reduce it.

Warning Signs

Each provider was asked what would be a warning sign or a cue to them that something was fundamentally wrong and that a senior could be a possible victim of elder bsuse. Two standard responses were: (1) suspicious injuries and (2) consistency of behavior. However, seven

other general categories emerged: medical manifestations, interpersonal relationships, neglect, home and living environment, finances, depression, and physical disintergration. These nine categories were not mutually exclusive:

1. Suspicious injuries: bruises, welts, broken teeth, broken glasses; injuries unlikely to have "just happened"; injuries not necessarily admitted to
2. Consistency of behavior: change in behavior; change in personality; apathy, lack of appetite; change in lifestyle, drops out of activities; discontinues services; frightened; upset
3. Medical manifestations: not complying with medical requirements (doctor's orders); not taking medication; over-self medication; chronically ill; not following diet; wants to see the doctor more; sudden physical complaints
4. Physical deterioration: change in physical condition; change in appearance; disorientation
5. Depression: not sleeping; weight loss; mental outlook; refusal to make plans; giving up; concern about finances
6. Home and living environment: lack or no clean linens; reaches out for attention; cleanliness of clothing and body; atmosphere empty cupboards

7. Finances: lack of apparent income when money should be available; inability to account for the outgo of money; pay too much for jobs; items missing from the household; no money for food or medicine
8. Neglect: malnutrition; filth; isolation; lack of food and/or medicine; broken teeth; broken glasses
9. Interpersonal relationships:

   Caregiver: won't allow senior to talk with someone alone; difficult to access to senior; belligerency on part of caretaker; hesitant to answer simple, nonthreatening questions; anger between elder and caregiver; strong negative feelings; quality of communication between elder and caregiver

   Family members: anger between family and senior; quality of communication, lack of contact between elder and family even though nearby; isolation; apathy by family about seniors' problems; failure to provide food, medicine; older people with siblings at home; recent death in family; alcohol/drug abuse; history of child abuse; loss of a spouse's job at age 60; frustration with deterioration of physical activities; children assuming parental roles

Seniors per se: reluctance to accept help, and/or have people come in even though there is an apparent need; hesitancy to discuss things; denies something wrong; makes excuses for family members

With one exception, providers who had programs which necessitated the senior to physically come to the site for services felt that their clients were unlikely victims of abuse. Consequently these providers were not as conscious of potential warnings. However, one service provider did provide a list of warning signs that are applicable for providers with site programs:

1. break from set routine
2. can't be reached on phone
3. stops interacting with "groups"
4. reluctant to talk about family at all
5. discrepancy about family stories
6. outgoing--then apathetic
7. very bright, alert--then erratic, disoriented, confused
8. feelings hurt rapidly
9. cleanliness, body odors, feebleness
10. body language very affectionate--then withdrawal
11. picking out certain individual and staying very close--need to "touch with words"

In addition to the specific warning signs, the service providers recommended three general guidelines for assessing potential elder abuse:

1. be very observant and look for non-verbal clues
2. listen to what the senior is really saying
3. be very cautious in drawing conclusions about the situation

Trust Building

In dealing with a problem such as elder abuse, trust and communication between the older client, other family members and the service provider is crucial. It is one level of trust that allows an older person to accept services and another level that allows an older person to confide and share personal concerns including family conflicts.

Every service provider interviewed acknowledged the importance of trust building. They shared many different methods and techniques that have worked for them. Two methods were consistently and repeatedly given as responses: firstly, trust building requires repeated contact and will develop only over a period of time and secondly, the service provider needs to emphasize confidentiality. Listed below are the trust building techniques most often given by service providers. They are the responses of providers who have worked with a variety of older clients in a variety of situations.

Establishing a relationship with older clients:

1. Repeated contact on a regular basis
2. Do not be derogatory about client's family
3. Respect the need for independence
4. Find a common interest or associate yourself with someone they know or trust
5. Encourage them to talk about themselves
6. Allow them to make decisions and acknowledge that they are in control of their life
7. Pick out and comment about a special quality of the person
8. Let them know that they are not alone; others have been in similar situations and resolved problems

Characteristics of service provider:

1. Importance of a smile and pleasant personality
2. Emphasize confidentiality and keep that trust
3. Use a service such as Circuit Breaker to establish rapport
4. Develop listening skills
5. Be emphatic, caring, and concerned
6. Be positive, not negative about family members
7. Develop exposure in the community and make yourself aware of all activities for seniors
8. If you promise an older client to do something, make sure you follow through

9. Try sharing or confiding about yourself to the person
10. Dress appropriately and use comfortable body language

Service providers were also asked on methods of building trust with family members. This would be of great importance if there is a neglectful or abusive situation. Suggestions included:

1. Be emphatic with family members concerning the stress of caring for older family members
2. Do not be critical or blame anyone directly
3. Be courteous
4. Offer information and options, not just solutions
5. Do not approach family members with ready-made answers but allow them to make decisions
6. Be supportive
7. Remember that many families are under a great deal of social and community pressure to care for older family members

Red Flags

If an older person is involved in a stressful situation such as family conflicts or abuse, a trustful relationship is crucial. To further build on this idea, service providers were asked to list "red flags" or behaviors that would alienate the older client and family members. The providers felt that attacking or

degrading the person's support system is one of the worst ways to handle the abusive situation. Even though the caregiver is abusive or neglectful, most older people do not see any other alternatives and will protect that caregiver.

There were other suggestions on how to avoid "red flags", and these are listed below.

Avoidance:

1. Avoid direct confrontations and coming on too strong
2. Avoid the phrase "I think you need this"
3. Avoid titles and bureaucratic talk
4. Avoid attacking or degrading support system
5. Avoid direct questions about financial situation
6. Avoid ready-made solutions but consider their right to decide
7. Avoid asking too many questions or appearing too eager to know information
8. Avoid talking down or patronizing older person

Alienation:

1. Do not move too fast, trust takes time; act quickly only if the situation is life threatening
2. Do not threaten their sense of security; the fear of the unknown may be greater than an abusive situation
3. Do not use nursing homes as a possible solution to problems

4. Do not show shock or be unaccepting of the person's situation; being judgemental will quickly alienate a person
5. Do not belittle a person's choice
6. Do not ask for person to sign alot of papers right away unless necessary
7. Do not "shuffle" a client off to another agency

Discussion

In Abuse and Neglect of the Elderly in Illinois (Crouse et al., 1981), three problems were identified as barriers to service provision to elder abuse victims: (1) the need to address legal issues; (2) the lack of protective service focus by providers; and (3) an undeveloped set of services to address the issue. These problems were clearly underscored in the providers' interviews and were intensified by uniqueness of a rural constituency.

Services to seniors in these counties are both fragmented and compartmentalized. For example, mental health centers may serve two counties; hospital facilities are not available in every county. When elder abuse was suspected, most providers approached the problem as an isolated phenomenon and did not network with other agencies for a resolution of the problem. Also no intervention strategies were articulated. Concern was expressed about legal ramifications of elder abuse and potential liability of intervening agencies.

Because of the nature of providing service to a rural clienteie, these problems were escalated. Isolation, which is a factor in elder abuse, is compounded when a service provider has clients living alone on remote farms without access to transportation or communication.

In addition to geographical problems, rural attitudes impacted upon the providers' willingness and even opportunities to intervene in elder abuse cases. Some communities pressure family members "to take care of their own" even though this process may heighten the abuse situations. Other communities "assume it is okay not to take care of their elderly", therefore, elder abuse is ignored and/or subtly condoned. A third attitude is "nobody really wants to get involved".

However, it should not be assumed that all rural communities are indifferent to the problems of their elderly. As one provider explained there tends to be fewer elderly in these lightly populated areas. This makes them easier to identify and "not get lost" in a larger general population. Continuing, this provider felt that rural communities tended to care more about their elderly in terms of neighborliness; telephone reassurance.

Regardless of the service capabilities or community attitudes, the senior's attitude toward relief of an abusive situation is the critical factor. The providers agreed that seniors:

1. fear being put into a nursing home. Threat of placement is a frequent form of abuse. Ironically many providers expressed personal distaste for nursing homes. One provider did suggest that in many cases care in a nursing home would be the ideal solution to abusive situations
2. are reluctant to seek help or to admit that there is a problem
3. fear change and fear the unknown
4. fear financial dependency

Summary

The Elder Abuse Awareness Project was undertaken to determine the incidence of abuse and neglect in a seven county region in Illinois. Based upon the results of interviews with service providers, there is both elder abuse and neglect in the seven counties.

Tangible products of this project for seniors were a set of transparencies and slides which were coordinated with an audio tape as a "packaged program" for seniors; a general brochure describing elder abuse, symptoms, and information and referral numbers; for service providers were a set of transparencies and slides which were coordinated with an audio tape and a study guide as a packaged program for service providers; a general informational

booklet based on audio visual materials; an intake card; and a final report. Copies of these materials are available upon request. Contact C.A.D.V., P. O. Box 732, Charleston, Illinois, Attention: Elder Abuse Awareness Project.

References

Block, M. R., & Sinnott, J. D. The battered elder syndrome: an explatory study. College Park: The University of Maryland Center on Aging, 1979.

Coyle, J. Elder abuse; bridging the aging and domestic violence networks. A paper presented at the 10th Annual Conference of the Mid-America Congress on Aging, Kansas City, 1983.

Crouse, J. S., Cobb, D. C., Harris, B. B., Kopecky, F. J., & Poertner, J. Abuse and neglect of the elderly in Illinois: incidence and characteristics, legislation and policy recommendations. Springfield, IL: Illinois Department on Aging, 1981.

Douglass, R. L. Domestic neglect and abuse of the elderly: implications for research and service. Family Relations, 1983, 32, 395-402.

U. S. Bureau of the census. Current population reports (Series p-25, No. 870). Washington, D.C.: U.S. Government Printing Office, 1980.

Bibliography

Block, M. R., & Sinnott, J. D. The battered elder syndrome: an exploratory study. College Park, MD: Center on Aging, University of Maryland, 1979.

Briley, M. Battered parents. Dynamic Years, January 1979, 24-27.

Crouse, J. S., Cobb, D. C., Harris, B. B., Kopecky, F. J., & Poertner, J. Abuse and neglect of the elderly in Illinois: incidence and characteristics, legislation and policy recommendations. Springfield, IL: Illinois Department on Aging, 1981.

Douglass, R. L. Domestic neglect and abuse of the elderly: implications for research and service. Family Relations, July 1983, 395-402.

The elderly: newest victims of familial abuse. Journal of American Medical Association, 1980, 243, pp. 1221; 1225.

Fulmer, T. T. Elder abuse in the family: the hidden victim. Aging and Leisure Living, 1980, 3, 9-12.

Hedge, C. A. Our abused elderly. Presbyterian Survey, September 1983, 17-18.

Hickey, T. & Douglass, R. L. Mistreatment of the elderly in the domestic setting: an exploratory study. American Journal of Public Health, 1981, 71, 500-507.

Kosberg, J. I. (Ed.). Abuse and maltreatment of the elderly: causes and interventions. Boston: John Wright-PSG INc., 1983.

Marcini, M. Adult abuse laws. American Journal of Nursing, 1980, 80, 739-740.

O'Malley, H. Elder abuse: a review of the literature. Boston: Legal Research and Services for the Elderly, 1979.

Ornstein, S. Abuse and neglect. Journal of New York State Nurses Association, 1975, 6, 35-38.

Rathbone-McCuan, E. Elderly victims of family violence and neglect. Social Casework: The Journal of Contemporary Social Work, 1980, 61, 296-304.

Steinmetz, S. K. Elder abuse. Aging, 1981 (315-316), 6-10.

U. S. Congress, House. Committee on Aging, Subcommittee on Human Services. Domestic abuse of the elderly. (Briefing, 96th Congress, 2nd session). Washington, D. C.: Government Printing Office, 1980.

U. S. Congress, House. Committee on Aging, Subcommittee on Human Services. Domestic violence against the elderly. (Hearing, 96th Congress, 2nd session). Washington, D. C.: Government Printing Office, 1980.

U. S. Congress, House. Select Committee on Aging. Elder abuse, an examination of a hidden problem. (Report, 97th Congress, 1st session). Washington, D.C.: Government Printing Office, 1980.

U. S. Congress, Senate and House. Special Committee on Aging, Select Committee on Aging. Elder abuse. (Joint Hearing, 96th Congress, 2nd session). Washington, D. C.: Government Printing Office, 1980.

Walshe-Brennan, K. Granny bashing. Nursing Mirror, 1977, 145, 32-34.

Waserman, S. The abused parent of the abused child. Children, 1979, 14, 175-179.

Wilner, C. T. Counseling in the homesetting: prevention and intervention in elder abuse. St. Louis, MO: The Jewish Hospital Department of Home Care.